REQUEST FOR RESTRICTION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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THIS FORM WILL ALLOW ME, AS A PATIENT OF THE COLON, STOMACH AND LIVER CENTER, TO REQUEST A RESTRICTION ON THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI). I UNDERSTAND THE COLON, STOMACH AND LIVER CENTER WILL CONSIDER ALL REQUESTS FOR RESTRICTIONS CAREFULLY; HOWEVER, THE COLON, STOMACH AND LIVER CENTER IS NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION.

VERIFICATION: (Please Print)

Patient's Name: _____ Date of Birth: _____

Contact Number: _____

The Colon, Stomach and Liver Center will not disclose confidential information without your authorization unless it is necessary to provide you care and assistance as a patient of our practice, or as otherwise required or permitted by law. We will not, for example, give your confidential information to a credit agency, a telemarketer or a prospective employer. We will not sell, rent or license the confidential information you provide to us. You do not need to request a restriction if you are concerned those uses and disclosures.

REQUESTED RESTRICTIONS:

Please describe your request: _____

_____

_____

PLEASE NOTE:

- Communications, including communications containing PHI, will continue to be sent to the current address we have on file for you (if necessary)
- If any information on this form is not complete, The Colon, Stomach and Liver Center will return the form to you, and your restriction request will not be considered until The Colon, Stomach and Liver Center receives complete information.
- You may change or revoke this this restriction by sending a written request to The Colon, Stomach and Liver Center at the address shown above.

SIGNATURE:

I have read and understand the above information Date: _____

Signature of Patient, Parent/Guardian, Personal Representative: _____

Relationship if signed other than Patient: _____

Note: if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If a Parent/Guardian makes a request, complete the following: the Patient is a minor ____ of age.

If you are a parent or guardian requesting a restriction on a child that will prevent the child's other legal parent from accessing the child's PHI, you must:

1. Provide evidence that the parental rights of the other parent have been terminated, or
2. Obtain the other parent's agreement to this restriction. If you obtain the other parent's agreement to this restriction, please have the other parent sign this form and notarize it, or send a statement signed and notarized by both parents indicating that both parents have agreed to place a restriction on the child's PHI.